Patient Registration
Date_____

Last Name _____ First Name_____ Preferred name_____

Address _____City _____State _____ Zip _____

Home phone _____ Fax _____ Cell _____ e-mail _____

Birth date _____ Married ___ Single ___ Divorced ___ Widowed ___

Employer's name _____ How long? _____

Address _____ Phone no. _____Occupation _____

Name of Spouse (or parent if a minor): Name _____

Employer Name and address_____Work# _____

Person Financially Responsible for account
Name _____ Relationship to Patient _____
Address _____ City _____State _____ Zip _____ Phone no._____

Primary Insurance Carrier information
Insurance company _____ Group No. _____Employer Name _____
Subscriber Name _____ Social Security No. _____
Subscriber Date of Birth _____

Secondary Insurance Carrier information
Insurance company _____ Group No. _____Employer Name _____
Subscriber Name _____ Social Security No. _____
Subscriber Date of Birth _____

Who can we thank for referring you to our Practice? _____

Consent for treatment

1. I hereby authorize doctor or designated staff to take radiographs, study models, photographs, and other diagnostic aids deemed appropriate by doctor Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

2. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

3. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.
4. I understand that notice for a change in my appointment must be given at least one weekday (Mon.-Fri.) in advance to a staff member or doctor to avoid a charge to my account.

Patient signature
_____Date_____Witness_____

Parent/Responsible Party's signature _____Relationship_____